AFFIRMATION (required for all grant submissions)

Office of Emergency Medical Services, 109 Governor Street, Suite UB-55, Richmond, VA 23219

The Authorized Agent and Financial Officer, whose names and signatures appear below, have been designated by the agency/organization to complete and submit a grant request on its behalf. The agency/organization agrees to comply with the Rules and Regulations Governing Financial Assistance for Emergency Medical Services for Rescue Squad Assistance Fund requests. In addition, the Authorized Agent and Financial Officer attest to the agency's or organization's ability to provide the matching funds (if required) to complete the purchase of the requested item(s), should they be awarded state funds. The Authorized Agent and Financial Officer are aware that EMS vehicles and equipment purchased with state monies must be purchased without any financial liens and without the item being used as collateral to secure a loan of any kind. The Authorized Agent and Financial Officer, by signing below, attest to the fact that the Agency(s) that are affected by the possible outcome of this grant request, have been notified and agree to its submission. RSAF Requests: The Authorized Agent and Financial Officer, by signing below attest that to the best of his/her knowledge, the information contained herein with regard to the agency's financial condition is true, accurate and correctly reflects the financial condition of the agency/organization. ***The OMD signature is required all for grants. This form must be received by the grant deadline date with original signatures from the Authorized Agent, Fiscal Officer and Operational Medical Director (OMD).***

Request for Federal/Employer Identification Number (required)

Business Name (as shown on your income tax return)

_____

Business name, if different from above (Doing Business As (DBA))

_____

Address (number, street, and/or suite no. per FIN)

_____

City, State, and Zip code _____

Federal Identification Number _____

	Authorized Agent	Financial Officer	Operational Medical Director (OMD)
Name:			
Title:			
Phone:			
E-Mail:			
Signature:			

Point of Contact for Grant Management:

Name: **Agency:**

Phone: **Email:**

OPTIONAL: City/County Representative

City/County representative shown below has been informed of the _____request for grant funds.

Printed Name _____ Title _____

Brief Project Description: (*REQUIRED*)

Project/Equipment Sustainability: (*REQUIRED*)

(How does your agency propose to sustain this project/equipment after funding is complete?)